



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

# Inflammatory Bowel Disease

**Q: What is inflammatory bowel disease (IBD)?**

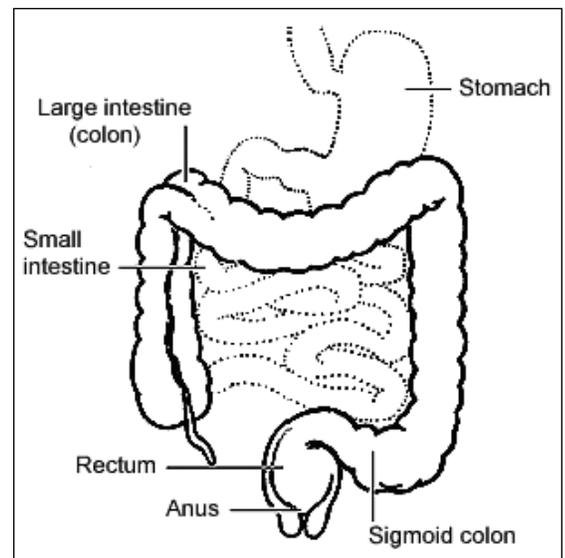
**A:** Inflammatory bowel disease (IBD) is an ongoing or chronic health problem that causes inflammation and swelling in the digestive tract. The irritation causes bleeding sores called ulcers to form along the digestive tract. This in turn can cause crampy, abdominal pain and severe bloody diarrhea.

There are two main types of inflammatory bowel disease: ulcerative colitis (UC) and Crohn's disease (CD). The diseases are very similar. In fact, doctors often have a hard time figuring out which type of IBD a person has. The main difference between UC and CD is the area of the digestive tract they affect. CD can occur along the entire digestive tract and spread deep into the bowel wall. In contrast, UC usually only affects the top layer of the large intestine (colon) and rectum. Medicine can control the symptoms of IBD in most women. But for people who have severe IBD, surgery is sometimes needed. Over the course of a person's life, the symptoms of IBD often come and go. With close monitoring and medicines, most people with IBD lead full and active lives.

**Q: How does a healthy digestive system work?**

**A:** A normal digestive system breaks down food into smaller pieces called nutrients. The body needs nutrients to

stay healthy. Food moves from the esophagus down to the small intestine, where the nutrients are absorbed into the blood. Leftover water and solid waste then move down into the large intestine (colon). Most of the water is absorbed back into the bloodstream there. Solid waste leaves the body through the rectum and out the anus as a bowel movement.



**Q: Who gets inflammatory bowel disease (IBD)?**

**A:** People of every race, sex and class all over the world have IBD. But researchers have found that IBD is more common among certain groups of people. These include:

- people who have a family member with IBD
- white people of Jewish decent
- people of higher socioeconomic classes
- people who live in cities
- people who live in developed countries



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

Smoking also seems to affect a person's risk of getting IBD. People who smoke are more likely to develop CD. On the other hand, smoking seems to reduce a person's risk of UC.

More than 1 million people in the United States alone have IBD. About 30,000 people discover they have IBD each year in this country. Most people find out they have IBD between the ages of 15 and 35. Approximately the same number of women and men get IBD.

**Q: What causes inflammatory bowel disease (IBD)?**

**A:** No one knows for sure what causes IBD. But, researchers think the following things may all play a role:

- a faulty immune system
- heredity
- environment

Many researchers think that abnormal action of a person's immune system may trigger IBD. Normally, the immune system protects the body from infections caused by viruses or bacteria. Once the infection has cleared up, the immune system "shuts off."

But in people with IBD, the immune system seems to overreact to something in the digestive tract. And once it starts working, the immune system in IBD fails to "shut off." This causes the ongoing inflammation, ulcers and other problems of IBD. Some researchers think a virus or bacterium may trigger the immune system to act this way.

IBD clearly tends to run in families. Roughly 10 to 30 percent of people with IBD have a relative with the disease. Women who have family members with IBD have at least 10 times the

chance of developing IBD compared with other people.

This suggests that inherited factors called genes play a role in IBD. In 2001, researchers found the first gene involved in CD. People with CD are twice as likely to have an abnormal form of the gene known as Nod2 compared with people in the general population. People with the abnormal form of this gene have a harder time fighting bacteria. People who have the Nod2 gene also are more likely to have disease of the last part of the small intestine called the ileum.

Some things in a person's environment also seem to boost a person's chances of getting IBD. These include:

- a lifestyle that includes little physical activity
- higher socioeconomic status
- living in a developed country

Contrary to popular belief, neither stress nor diet alone can cause IBD. But both can affect the symptoms. Stress can worsen the symptoms of IBD. Similarly, certain foods seem to aggravate IBD. By changing her diet and relieving stress, a woman can help control her symptoms of IBD.

**Q: What is ulcerative colitis (UC)?**

**A:** Ulcerative colitis (UC) is an ongoing health problem that causes inflammation and bleeding sores called ulcers in the top layers of the large intestine (colon) and rectum. It most often occurs in the lower part of the colon and rectum, but may affect the whole colon. When UC only occurs in the rectum, it is called proctitis. Most people find out they have UC between the ages of 15 and 40 years.



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

**Q: What are the symptoms of ulcerative colitis (UC)?**

**A:** The two most common symptoms of UC are diarrhea (often bloody) and crampy abdominal pain. Inflammation causes these symptoms. An inflamed bowel doesn't allow as much water to be absorbed into the blood. This makes the colon empty often in the form of diarrhea. Inflammation also causes bleeding ulcers. The ulcers typical of UC also can make pus and mucus.

Other common signs of UC include:

- nausea
- loss of appetite
- weight loss
- frequent fever

For most people, the symptoms of UC come and go. When they feel well, the UC is said to have gone into remission. When they feel sick, they are having a relapse or flare-up.

About half of the people with UC have only mild symptoms. For others, the symptoms of UC may be very uncomfortable. In severe cases, people can become malnourished and may need a special diet or to be fed fluids through a vein.

**Q: Can ulcerative colitis (UC) cause health problems in parts of the body other than the colon?**

**A:** Yes. UC can cause a number of problems outside of the colon including:

- joint pain or arthritis,
- inflammation in the eye,
- liver and bile duct disease,
- skin rashes,

- anemia, and
- kidney stones.

No one knows why these health problems are common in people with UC. The immune system may trigger inflammation in other parts of the body. These problems are usually mild and go away when the colitis is treated.

Osteoporosis is also more common among people with UC. This may be because their diets don't contain enough calcium and vitamin D. Plus, UC can prevent the body from absorbing enough calcium. Corticosteroids, medicines used to treat UC, can also boost a person's risk of osteoporosis.

**Q: How is ulcerative colitis (UC) diagnosed?**

**A:** If you suspect you have UC, talk to your doctor. She will use your health history, a physical exam, and many different tests to figure out if you have UC.

Tests used to diagnose UC include:

- **Blood tests:** A sample of blood is studied in a lab to find signs of inflammation and anemia.
- **Stool sample:** A sample of a bowel movement is tested for blood or infection.
- **Barium Enema:** The doctor injects fluid containing a substance called barium into the rectum. The barium allows the doctor to see the colon on an x-ray. Using this x-ray, doctors can "see" if there are any ulcers or other signs of UC.
- **Flexible Sigmoidoscopy:** The doctor puts a thin tube with a light into the rectum. It allows the doctor



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

to check the rectum and the lower part of the colon for signs of UC.

- **Colonoscopy:** The doctor puts a thin tube with a light through the rectum and into the colon. This allows her to “see” the lining of the whole colon and check for signs of UC.

### Q: What is Crohn’s disease (CD)?

Crohn’s disease (CD) is an ongoing health problem that usually causes inflammation deep in the walls of the large intestine (colon) and/or the small intestine. But CD can affect any part of the digestive tract from the mouth to the anus. The inflammation usually causes abdominal pain and diarrhea. In other cases CD may cause constipation. Nearly half of all CD cases involve both the small and large intestine. About 30 percent of the time, CD occurs in the small intestine, usually in the ileum (the last part of the small intestine that connects to the large intestine or colon). And about 20 percent of the time, CD affects only the colon. Like UC, people with CD also have periods of remission and relapse.

### Q: What are the symptoms of Crohn’s disease (CD)?

- A:** The symptoms of CD depend upon what part of the digestive system is affected. Since CD usually occurs in the last part of the small intestine (ileum) and in the nearby part of the colon, the most common symptoms are pain and tenderness in the abdomen, especially the lower right side and diarrhea. The symptoms of Crohn’s disease may be mild or severe. And they often come and go.

Other less frequent signs of CD include:

- constipation
- weight loss
- rectal bleeding
- low grade fever
- low levels of iron in the blood (anemia)
- exhaustion
- slowed growth and delayed sexual development in childhood cases

### Q: What are the complications of Crohn’ disease (CD)?

- A:** In some people with CD, swelling and scar tissue thicken the bowel wall. This can close off the intestines causing an intestinal blockage. Intestinal blockages cause constipation, bloating, and other problems.

Sometimes the ulcers of CD can break through the walls of the intestine. They then create tunnels or fistulas between the involved intestine and another part of the intestine or nearby organs. Fistulas usually occur in other parts of the intestines or the bladder, vagina, or skin. They are common around the anus and rectum. Mucus, pus, or stool can drain from infected fistulas in this area.

Many people with CD also suffer from nutritional problems. Their damaged digestive systems may not absorb enough proteins, calories, vitamins or minerals. Osteoporosis also is a threat because CD can prevent the body from absorbing enough calcium and vitamin D. Medicines used to treat CD called corticosteroids also increase the risk of osteoporosis. People with CD who do



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

not include enough milk products or vitamin D in their diets have an even higher risk of osteoporosis.

**Q: Can Crohn's disease (CD) cause health problems throughout the body?**

**A:** Yes. CD can cause a number of problems outside of the digestive system including:

- joint pain or arthritis,
- inflammation in the eye and mouth,
- gallstones,
- several liver diseases,
- skin rashes,
- low level of iron in the blood or anemia, and
- kidney stones.

Some of these problems get better when the Crohn's disease is treated. Others must be treated separately.

**Q: How is Crohn's disease (CD) diagnosed?**

**A:** If you think you might have CD, talk to your doctor. She will use your health history, a physical exam, and several tests to figure out if you have CD.

Tests used to diagnose CD include:

- **Blood tests:** A sample of blood is studied in a lab to find signs of inflammation and anemia (low iron levels).
- **Stool sample:** A sample of a bowel movement is tested for blood or infection.
- **Upper Gastrointestinal (GI) Series with Small Bowel Follow-Through:** The patient drinks a

chalky liquid that contains barium. Then x-rays are taken. Barium shows up on x-rays. This allows the doctor to "see" the upper part of the digestive system including the esophagus, stomach, and small intestine. The doctor uses this test to check for signs of CD.

- **Barium Enema:** The doctor injects fluid containing a substance called barium into the rectum. Barium allows the doctor to see the colon on an x-ray. Doctors use this x-ray to "see" signs of CD.
- **Flexible Sigmoidoscopy:** The doctor puts a thin tube with a light into the rectum. It allows the doctor to check the rectum and the lower part of the colon for signs of CD.
- **Colonoscopy:** The doctor puts a thin tube with a light through the rectum and into the colon. This allows her to "see" the lining of the whole colon and check for signs of CD.
- **Computerized Axial Tomography (CT or CAT Scan):** The patient drinks liquid containing barium and sometimes has a dye injected into their blood. Barium and this special x-ray dye show up on CT scans. Then the doctor uses a special machine to take many x-rays at different angles from around the body. The doctor studies the images with a computer. CT scans can spot inflammation, narrowing of the intestines, abscesses and blockages.

It often takes a while for doctors to make the correct diagnosis. This is because the symptoms of CD vary and are similar to those of many other problems.



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

**Q: Is inflammatory bowel disease (IBD) the same thing as Irritable Bowel Syndrome (IBS)?**

**A:** No. Inflammatory bowel disease, including UC and CD, is different from irritable bowel syndrome (IBS). Unlike IBD, IBS does not cause inflammation, ulcers or other damage to the bowel. Instead, IBS is a much less serious problem called a functional disorder. This means that the digestive system looks normal but doesn't work as it should. Symptoms of IBS may include crampy pain, bloating, gas, mucus in the stool, diarrhea and constipation. IBS has also been called spastic colon or spastic bowel.

**Q: When should I call my doctor?**

**A:** It is important to call your doctor if you see blood in the stool, have a change in bowel habits that last more than 10 days, or if you have any of the following symptoms that do not improve with over-the-counter medicines.

- Severe abdominal cramps or pain
- Severe diarrhea or bloody diarrhea
- Weight loss
- Unexplained fever lasting more than 3 or 4 days
- Exhaustion
- Loss of appetite
- Nausea

**Q: Can I do anything to avoid getting inflammatory bowel disease (IBD)?**

**A:** Since doctors don't know exactly what causes IBD, there is no proven way to prevent it.

**Q: Aside from taking medicine, what can I do to treat the symptoms of inflammatory bowel disease (IBD)?**

**A:** For some people, changes in diet and lifestyle help control the symptoms of IBD.

In terms of diet, there are no blanket rules. Dietary changes that help one person with IBD may not relieve symptoms in another. Talk to your doctor and nutritionist about what you should and should not be eating. Recommendations will depend on the part of your intestine that is affected and which disease you have.

Your doctor may suggest some of the following changes in diet:

- taking specific nutritional supplements,
- limiting dairy products,
- eating low-fat foods,
- avoiding "gassy" or highly seasoned foods
- avoiding foods high in undigestible fiber
- following doctor-recommended diets and
- eating smaller, more frequent meals.

More than half of people who have CD in their small bowel develop narrowing of the lower small intestine (ileum). For these people, a special diet called a *low-residue diet* may help relieve abdominal pain and other symptoms. This diet restricts the amount of nuts, seeds, and raw fruits and vegetables a person can eat.

Getting enough rest, regular exercise and reducing stress also seem to



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

improve symptoms. Talk to your doctor about things you can do to feel better.

**Q: How is inflammatory bowel disease (IBD) treated?**

**A:** Doctors treat IBD in order to improve symptoms and decrease the amount of inflammation. Treatment for IBD may include:

- dietary changes
- lifestyle changes like stress reduction
- medicine
- surgery

The recommended treatment for IBD depends on:

- the type and severity of symptoms
- location of disease
- complications

People who have mild or no symptoms may not need treatment at all. But most people with IBD take medicine to control their symptoms. And many people with severe IBD need surgery to control the disease.

**Q: What medicines are used to treat inflammatory bowel disease (IBD)?**

**A:** Treating IBD with medicine is complicated. You may need to take several different medicines before you find the one that works best for you. It is very important to keep track of how well the drugs are working, the side effects you are having, and report all details to your doctor. The following kinds of medicines are used to treat IBD:

**Aminosalicylates**

Most people with mild to moderate IBD are first treated with medicines called aminosalicylates. These drugs help control inflammation.

Aminosalicylates contain a substance called 5-aminosalicylic acid (5-ASA). They come in many forms including pills, enemas, and suppositories.

Sulfasalazine was one of the first medicines in this group to be used for IBD. While it improves symptoms, sulfasalazine (which contains sulfa) also causes a lot of side effects. These include heartburn, nausea, vomiting, diarrhea, and headaches. Many people are allergic to sulfa drugs and cannot take these medicines.

Newer 5-ASA medicines include balsalazide, mesalamine, and olsalazine. These products have fewer side effects than the original 5-ASAs and still help many people with mild to moderate IBD.

**Corticosteroids**

Corticosteroids are used to treat people with more severe IBD and those who do not respond to 5-ASA medicines. These medicines help people with IBD by reducing inflammation. But they also have many side effects. These include bone loss, weight gain, acne, high blood pressure, mood swings, and a higher risk of infection. Prednisone, methyl prednisolone and hydrocortisone are commonly used steroids.

Budesonide is the first in a new group of corticosteroids called topical or non-systemic steroids. These medicines help people with IBD with fewer of the side effects of traditional corticosteroids.



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

Budesonide can be used to treat mild to moderate CD in the last part of small intestine (ileum) and the first part of the large intestine.

### Antibiotics

Antibiotics are also used to treat IBD. No one is sure how these medicines improve the symptoms of IBD. But many researchers think they give relief by working in the following two ways:

- interfering with the immune system
- decreasing the amount and changing the type of bacteria in the digestive system.

Metronidazole and ciprofloxacin are antibiotics often used to treat IBD. They can cause nausea, diarrhea and vaginal yeast infections as side effects.

### Immune System Modulators

Medicines called immunomodulators are often used to treat moderate to severe IBD. These drugs reduce inflammation by blocking the immune system. Azathioprine and 6-mercaptopurine (6-MP) are commonly used immunomodulators.

Immunomodulators take a long time (3 to 6 months) to work. So, they are often taken along with corticosteroids. Immunomodulators can be used to treat the people with IBD who:

- don't respond to aminosalicylates, corticosteroids and antibiotics
- can't bear the side effects of corticosteroids
- can't stop taking steroids without a relapse
- have open, draining fistulas
- need IBD to stay in remission

These medicines can be toxic to the bone marrow. They can also cause

serious side effects including liver and pancreas problems and increased risk of infection. So, doctors carefully monitor people taking immunomodulators.

### Biologic Therapy

Infliximab is a biologic therapy sometimes used to treat people with severe CD and UC. It is usually used for people who do not want to take corticosteroids or for those who do not respond to 5-ASA agents, corticosteroids, or immunomodulators. It can also be used to treat people with CD who have open, draining fistulas. Infliximab blocks the action of a protein in the body that causes inflammation. This, in turn, improves the symptoms of IBD.

Infliximab is given through a tube inserted into a vein. The most common side effects include breathing problems, low blood pressure, hives and headache. Very serious side effects are rare but have happened. They include sepsis, cancer, bleeding disorders, and nervous system problems.

### Over-the-counter Medicines

Drugs like antidiarrheals, laxatives, and pain relievers are sometimes used to treat IBD. It is important to talk with your doctor before taking any of these medicines. Some can actually make symptoms worse.

### Q: What types of surgery are used to treat inflammatory bowel disease (IBD)?

**A:** Sometimes severe IBD does not get better with medicine. In these cases, doctors may suggest surgery to fix or remove damaged parts of the intestine. There are different types of surgery used to treat IBD.



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

### **Surgery for Crohn's Disease**

About 75 percent of people with CD need surgery at some point in their life. Surgery can relieve symptoms and correct problems like blockages, fistulae or bleeding in the intestine. After surgery, some people are able to stop taking daily medicines for CD.

Surgery can help relieve the symptoms of CD but cannot cure it. The inflammation tends to return next to the part of intestine that was removed. So, people considering surgery for CD should carefully weigh the risks and benefits.

Types of surgery for CD include:

**Stricturoplasty** In this surgery, the doctor opens up an area of the intestine that has gotten smaller because of CD. The area of the intestine that has narrowed is called a stricture. The doctor does not remove any of the intestine in this surgery.

**Small bowel resection** In this surgery, the damaged part of the intestine is removed and the two healthy ends are sewn back together.

**Colectomy** In this surgery, the doctor removes a part of the colon or the entire colon and rectum. The body needs the colon to move and get rid of waste. So after a colectomy the doctor must create a new way for waste to leave the body. This is now usually done by making an opening in the abdomen called a stoma. This hole allows for the drainage of stool from the large or small intestine. A pouch is worn over the opening to collect waste.

### **Surgery for Ulcerative Colitis**

About 20 to 40 percent of people with UC need surgery at some point in their lives. Doctors may suggest surgery for people with UC in the following cases:

- ongoing, severe symptoms
- symptoms that do not get better with medicine
- precancerous changes in the colon
- high risk for colon cancer

Some people with UC need emergency surgery. Doctors often perform emergency surgery to fix the following problems:

- severe bleeding
- a hole (perforation) in the colon
- build up of gas and bacteria inside the colon called toxic megacolon

Surgery that removes the entire large intestine can completely cure UC. Even though surgery can be risky, studies show it greatly improves the lives of people with UC. Surgery used to be considered a last resort for people with UC. But now some doctors suggest surgery for people in the earlier stages of the disease

Types of surgery for UC include:

**Proctocolectomy:** The doctor removes the entire large intestine including the colon, rectum and anus during this surgery. This is the most commonly recommended surgery for people with UC. It can be performed with an ileostomy or ileoanal pouch anal anastomosis (IPAA). For more details on these procedures see the section above on surgery for CD.

### **Ileal pouch anal anastomosis**

**(IPAA):** In this procedure, the very end of the small intestine (ileum) is made into a pouch. It is then connected to the anus. In this way, waste can once again leave the body through the anus. People who have IPAA do not need to wear a pouch outside their bodies. But



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

people who have IPAA have more complications than those who have an ileostomy. The most common problems with this surgery are blockages in the intestine and pouch inflammation or infection.

**Q: I have inflammatory bowel disease (IBD) and need surgery. Did I fail at managing my disease?**

**A:** No. Surgery for IBD is often seen as a “failure” by both the patient and her doctor. But studies show that it is sometimes the best choice for treating IBD.

Surgery can give lasting relief from symptoms and may even eliminate the need for medicine. Many people with severe IBD suffer from ongoing pain for years in order to put off surgery as long as possible. Recent research shows that this may not be the best plan. Some doctors now suggest surgery in the earlier stages of IBD instead of using it as a “last resort.”

**Q: What new treatments for inflammatory bowel disease (IBD) are being studied?**

**A:** Studies are looking at the use of human growth hormone (HGH) combined with a high-protein diet to treat CD. Limited research shows that people treated this way have fewer symptoms after one month. But the long-term risks and benefits of HGH are still unknown.

New medicines that block inflammation are being studied in people with both UC and CD. Researchers are also studying if a gene-based drug can help

grow healthy tissue in people with UC.

If you are interested in participating in a clinical study on IBD, visit the clinical trials website of the U.S.

National Institutes of Health:

<http://www.clinicaltrials.gov>

**Q: Since I have inflammatory bowel disease (IBD), do I have a higher chance of getting colon cancer?**

**A:** Yes. IBD can increase the chances of cancer of the intestine by as much as five times. Even so, more than 90 percent of people who have IBD do NOT get cancer.

**Q: I have inflammatory bowel disease (IBD). What things affect my risk of getting colon cancer?**

**A:** What we know about colon cancer and IBD comes mostly from studying people with UC. Less research has been done on the link between CD and cancer, but the few studies that have been done suggest the risk for cancer in people with CD is similar to the risk in those with UC. Even so, the things that affect the risk of cancer seem to be similar for both types of IBD.

The risk of colon cancer in people with IBD depends on the following:

- how long you have had IBD
- how much of your colon is affected by IBD

Also, people who have family members with colon cancer may have an even higher chance of getting the cancer.

For people with UC, the risk of colon cancer does not start to increase until they have had the disease for 8-10 years. People whose disease affects the



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

entire colon seem to have the highest risk of colon cancer. People who have inflammation only in the rectum seem to have the lowest risk.

**Q: I have inflammatory bowel disease (IBD). Should I get regular tests to check for colon cancer?**

**A:** Yes. People with IBD should talk to their doctors about when to begin checking for colon cancer, what tests to get, and how often to have them. Your doctor's suggestions will depend on how long you have had IBD and how severe it is.

In people who have had IBD for 8 to 10 years, most doctors recommend a colonoscopy with biopsies every 1 to 2 years. This test checks for early warning signs of cancer in the cells of the colon lining. When cancer is found early, it is easier to cure and treat.

During a colonoscopy, the doctor inserts a thin, lighted tube into the anus to examine the lining of the colon. At the same time, the doctor takes one or more small samples of tissue from the colon. This is called a biopsy. Doctors use a microscope to look for changes in cells of the colon that warn of cancer or for signs of cancer itself.

**Q: Does inflammatory bowel disease (IBD) increase my chances of getting cancer in places outside of the digestive system?**

**A:** Some studies have found that persons with IBD have a higher risk for cancers other than colon cancer. No one knows for sure why. Skin cancers seem to be more common in people with CD. Some studies show that people with

UC have a higher chance of getting cancer of the gallbladder and bile ducts.

**Q: Do women with inflammatory bowel disease (IBD) have problems getting pregnant?**

**A:** Not usually. Women with UC seem to get pregnant as easily as other women. But some studies suggest that women with active CD have more problems with fertility than other women. Plus, women who have had surgery for IBD, particularly an IPAA, have more difficulty getting pregnant than women in the general population.

**Q: Is pregnancy safe for women with inflammatory bowel disease (IBD)?**

**A:** Women with IBD should talk with their doctors **before** getting pregnant. If you think you might be pregnant, it is important to call your doctor immediately. Some of the medicines used to treat IBD may harm the growing fetus. Research shows that it is best for women with IBD to get pregnant while their disease is inactive (in remission). If the baby is conceived at this time, most women with IBD seem to have fairly normal pregnancies. But when a woman gets pregnant while her disease is active, IBD usually stays active or can get worse. Flare-ups usually happen in the first trimester and right after the baby is born.

Limited research shows that some medicines used to treat IBD are safe or likely safe in pregnancy. A few studies have shown that taking prednisone, sulfasalazine, and 5 ASAs during pregnancy does not hurt the developing fetus. But the effects of other medicines on



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

pregnancy have not been well-studied. Surgery, if necessary, is safest in the second trimester.

**Q: Does inflammatory bowel disease (IBD) harm a developing fetus or affect delivery?**

**A:** Not usually. Most women with IBD have normal deliveries and healthy babies. But women with active CD do have a greater chance of some problems compared with the general population. Giving birth early (pre-term birth), stillbirth and miscarriage are more common in pregnant women with active CD than in other women.

**Q: Can inflammatory bowel disease (IBD) affect my monthly period?**

**A:** Yes. Many women with active IBD have irregular periods. When the disease goes into remission, regular periods sometimes return. No one knows for sure why. But inflammation does affect the hormones that cause periods. Nutritional problems may also interfere with the monthly cycle of women with IBD.

Some women with IBD tend to feel worse right before and during their menstrual periods than at other times. Diarrhea, abdominal pain, exhaustion and other symptoms are often more severe during these times. It is important for women and their doctors to keep track of these monthly changes in symptoms. This will prevent over-treating the disease.

**Q: Can inflammatory bowel disease (IBD) affect my sex life?**

**A:** Yes. Some women with IBD have pain or discomfort during sex. This can be caused by the disease itself, surgery, and emotional issues related to the disease. Women with IBD may have the following problems during sex:

- abdominal pain
- pain in the area between the vagina and rectum (perineal area)
- rectal pain
- feeling like they have to have a bowel movement
- embarrassment because of having a stoma
- fear of passing gas or stool

In women with CD, painful sex is often a sign of a fistula or abscess in the vagina or that the disease is affecting the perineal area. Most women with UC have relatively normal sex lives. But after surgery, sexual problems are more common in women with both UC and CD.

Emotional issues caused by IBD can also interfere with a woman's sex life. Women with IBD have less confidence in their bodies compared with other women. Studies show that women with IBD who are in stable relationships have sex less frequently than other women.

Even though it may be embarrassing, it is important to tell your doctor if you are having sexual problems. She can



**WomensHealth.gov**

**1-800-994-9662**

**TDD: 1-888-220-5446**

suggest helpful hints that will help you get back a healthy sex life. For example, some experts suggest that women who use enemas or suppositories do so after sexual intercourse. Plus, women with ileal stomas and external pouches may want to empty the bags prior to sexual relations. Sometimes women cover up their external pouches in ways that

make them feel less self-conscious and more attractive during sex.

Painful sex may be a sign that your disease is getting worse. So it is very important you talk to your doctor about any sexual problems. Your doctor may also be able to change your treatment program to make you feel better and in turn help your sex life. ■



WomensHealth.gov

1-800-994-9662

TDD: 1-888-220-5446

*For more information...*

Contact the National Women's Health Information Center at 1-800-994-9662 or the following organizations:

**National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK)**

Internet Address: [www.niddk.nih.gov](http://www.niddk.nih.gov)

**American Gastroenterological Association**

Phone Number(s): (301) 654-2055

Internet Address: [www.gastro.org](http://www.gastro.org)

**National Digestive Diseases Information Clearinghouse**

2 Information Way Bethesda, MD 20892-3570

E-mail: [nddic@info.niddk.nih.gov](mailto:nddic@info.niddk.nih.gov)

**North American Society for Pediatric Gastroenterology, Hepatology and Nutrition**

Phone Number(s): (215) 233-0808

Internet Address: [www.naspgn.org](http://www.naspgn.org)

**Crohn's & Colitis Foundation of America, Inc.**

Phone Number(s): (800) 932-2433 or (212) 685-3440

Internet Address: [www.cdfa.org](http://www.cdfa.org)

**Social Security Administration Information on Disability Benefits**

Phone Number(s): (800) 772-1213

Internet Address: [www.ssa.gov](http://www.ssa.gov)

**The American College of Gastroenterology**

Phone Number(s): (703) 820-7400

Internet Address: [www.acg.gi.org/](http://www.acg.gi.org/)

*This FAQ was adapted from the NIDDK's fact sheets, "Ulcerative Colitis" and "Crohn's Disease."*

This FAQ was reviewed by:

Jacqueline L. Wolf, M.D.

Associate Professor of Medicine

Harvard Medical School

Senior Physician

Beth Israel Deaconess Medical Center

December 2005